Senate Bill No. 398

CHAPTER 928

An act to add Sections 1366.1 and 1375.3 to the Health and Safety Code, relating to health care service plans.

[Approved by Governor September 25, 2002. Filed with Secretary of State September 26, 2002.]

LEGISLATIVE COUNSEL'S DIGEST

SB 398, Chesbro. Health care service plans: bankruptcy.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation and licensure of health care service plans by the Department of Managed Health Care and makes a violation of the act's provisions a crime. Under the act, a plan is required to demonstrate to the Director of the Department of Managed Health Care that it has a fiscally sound operation and adequate provision against the risk of insolvency. The act also requires a plan to provide notice of any material modification of its license to the director.

This bill would require a health care service plan, except in extraordinary circumstances, to meet and confer with the director at least 10 business days prior to filing a petition for bankruptcy. The bill would require in extraordinary circumstances, that the plan meet and confer with the department 24 hours before filing the petition. The bill would also require the plan to provide certain information requested by the director. The bill would also require the department to adopt regulations that establish an extended geographic accessibility standard for access to health care providers served by a health care service plan in counties with a population of 500,000 or less that have 2 or fewer health care service plans providing coverage to the entire county in the commercial market. The bill additionally would require a health care service plan at least 30 days prior to filing a notice of material modification to withdraw with the director, to hold a public meeting in a county with a population of 500,000 or less if the plan intends to withdraw from that county. Because the violation of these requirements would be punishable as a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1366.1 is added to the Health and Safety Code, to read:

1366.1. (a) The department shall adopt regulations on or before July 1, 2003, that establish an extended geographic accessibility standard for access to health care providers served by a health care service plan in counties with a population of 500,000 or less, and that, as of January 1, 2002, have two or fewer health care service plans providing coverage to the entire county in the commercial market.

(b) This section shall not apply to specialized health care service plans or health care service plan contracts that provide benefits to enrollees through any of the following:

(1) Preferred provider contracting arrangements.

(2) The Medi-Cal program.

(3) The Healthy Families Program.

(4) The federal Medicare program.

(c) At least 30 days before a health care service plan files a notice of material modification of its license with the department to withdraw from a county with a population of 500,000 or less, the health care service plan shall hold a public meeting in the county from which it is intending to withdraw, and shall do all of the following:

(1) Provide notice announcing the public meeting at least 30 days prior to the public meeting to all affected enrollees, health care providers with which it contracts, the members of the board of supervisors of the affected county, the members of the city councils of cities in the affected county, and members of the Legislature who represent the affected county.

(2) Provide notice announcing the public meeting at least 15 days prior to the public meeting in a newspaper of general circulation within the affected county.

(3) At the public meeting, allow testimony, which may be limited to a certain length of time by the health care service plan, of all interested parties.

(4) File with the department for review, no less than 30 days prior to the date of mailing or publication, the notices required under paragraphs (1) and (2).

(d) The department may require a health care service plan that has filed to withdraw from a portion of a county with a population of less than 500,000, to hold a hearing for affected enrollees.

(e) A representative of the department shall attend the public meeting described in this section.

SEC. 2. Section 1375.3 is added to the Health and Safety Code, to read:

1375.3. (a) A health care service plan shall meet and confer with the director and his or her designated representatives at least 10 business days prior to filing a petition commencing a case for bankruptcy under Title 11 of the United States Code, except under extraordinary circumstances. If extraordinary circumstances preclude a meet and confer with the director within the 10-day time period prior to the filing of a petition for bankruptcy, the plan shall meet and confer with the department at least 24 hours prior to filing the petition. A plan shall notify the department concurrently upon filing the petition. These meetings shall be deemed confidential.

(b) At the director's request, a plan shall provide within the time period specified by the department, information to assist in ensuring continuity of care and uninterrupted access to health care services for plan subscribers and enrollees. The information may include, but is not limited to, the following:

(1) A list of all providers with which the plan contracts and material information regarding the contracts including, but not limited to, the grounds for termination of the contract and the term remaining on the contract.

(2) A list of employer groups who subscribe with the plan.

(3) A list of the enrollees of the plan.

(4) A list of enrollees undergoing current treatment and a description of the authorized treatment for the enrollee.

(5) A list of all brokers and agents involved in the negotiation of subscriber contracts.

(6) A list of all enrollees who contract as individual subscribers for coverage by the plan.

(c) Notwithstanding subdivision (a), nothing in this section shall preclude the director from exercising powers and duties authorized under this chapter.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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